Arizona Department of Health Services
Office for Children with Special Health Care Needs

TRANSITION PLANNING FORM

Part I

Invitation to Participate in a Transition Planning

TO: _____
(Name)

You are invited to a meeting to develop the transition plan for _____ who is currently
(Member's Name)
enrolled in our agency's _____ program. The member's date of birth is _____.

The meeting will assist the member/family to understand and plan the transition process.

The meeting will be held at:

Location: _____

Date: _____ Time: _____

The members of the Transition Planning Team are:

_____ Member

_____ Parent

_____ ADHS/OCSHCN Family Resource Coordinator

_____ Provider from the Individual Service Plan Team

_____ Provider from the Individual Service Plan Team

_____ School Representative

_____ School Representative

_____ Other

_____ Other

Please bring any necessary forms and materials to this Transition Planning Conference to assist you in:

- Providing information to the member/family about all available programs
- Providing information to the member/family.
- Consent forms to conduct further evaluation if needed.
- Other information needed to facilitate a timely, seamless transition.

If I can provide further information or if your schedule conflicts with the meeting date, please call.

_____ _____
Family Resource Coordinator's Name Agency

_____ _____
Phone Number Date

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Transition Planning Form

Part II

Summary

Member's Information			
Member's Full Name (Last, First, Middle)	Date of Birth	Date of Transition Meeting	
Member's Address	City	State	Zip Code
Primary Language of Home	English Proficient ___ Yes ___ No		
Guardian/Parents' Names			
Address	City	State	Zip Code

Participants in the Transition Meeting

Relationship to Member	Signature	Phone Number
Self		
Guardian/Parent(s)		
Family Resource Coordinator		
Provider from the Service Plan Team		
School Representative		
Other		
Other		

Summary

Action Steps	Timeline	Person(s) Responsible